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Original Article

Diagnostic challenges of undiagnosed mycosis fungoides initially treated as chronic eczema: A retrospective study from Kosovo (2016–2024)

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ABSTRACT

Background: Mycosis fungoides (MF), the most common primary cutaneous T-cell lymphoma, often presents nonspecific eczematous or psoriasiform lesions, which frequently results in diagnostic delay. **Objectives:** To evaluate the clinical features, diagnostic challenges, and misclassification patterns of MF patients who were initially treated as chronic eczema in Kosovo. **Methods:** A retrospective study was conducted including 16 patients diagnosed with MF between 2016 and 2024 at the University Clinical Center of Kosovo. All diagnoses were confirmed histopathologically and immunohistochemically. Demographic data, duration before diagnosis, clinical features, and outcomes were analyzed. **Results:** Among 16 patients (14 males, 2 females; mean age 58.2 ± 6.4 years), the mean diagnostic delay was 12.6 ± 7.4 months (range 6–24). All patients had previously been treated as chronic eczema; most had received prolonged topical corticosteroids. One patient progressed to tumor-stage MF and died, while another reported a family history of chronic lymphocytic leukemia. Immunohistochemical analysis confirmed a predominant $CD3^+/CD4^+$ phenotype with clonal TCR expression. **Conclusions:** MF continues to be underrecognized in its early phases, often mistaken for eczema. Persistent or treatment-resistant dermatitis should prompt early biopsy and clinicopathologic correlation to avoid diagnostic delay and improve prognosis.

Key words: Mycosis fungoides, Diagnosis, Clinical challenge, Immunohistochemistry

INTRODUCTION

Mycosis fungoides is a primary cutaneous T-cell lymphoma characterized by a slow progression through patch, plaque, and tumor stages [1-3]. In its early phases, MF frequently resembles benign inflammatory dermatoses, making diagnosis challenging even for experienced clinicians [4,5].

The subtle and variable clinical presentation, along with histopathologic overlap with chronic dermatitis, commonly leads to misdiagnosis and delayed treatment [4]. International literature reports diagnostic delays ranging from months to several years, often impacting long-term outcomes [2,6,7].

In our setting, patients frequently receive multiple prior treatments for presumed chronic eczema, sometimes for extended periods, before a biopsy is considered. This study presents our institutional experience with patients whose initial diagnosis was eczema but were later confirmed to have MF.

MATERIALS AND METHODS

This retrospective study included all patients diagnosed with MF from 2016 to 2024 at the Department of Dermatology, University Clinical Center of Kosovo. The inclusion criteria were:

1.Histopathologic confirmation of MF [1,4]

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2. Initial misdiagnosis as eczema or chronic dermatitis [5].
3. Available follow-up data:

Biopsies were reviewed by dermatopathologists and analyzed by immunohistochemistry (CD3, CD4, CD8, CD30, TCR) [4]. Data extracted included demographic information, clinical characteristics, duration before diagnosis, staging, and patient outcomes.

According to WHO-EORTC classification and staging recommendation [1,8].

Descriptive statistics were performed using standard analytical methods.

RESULTS

Sixteen patients, 14 males and two females, fulfilled the inclusion criteria. Demographic characteristics and clinical features are detailed in Tables 1 and 2 respectively. Most had been treated for months with topical therapies for presumed eczema. Initial symptoms and previous treatments are shown in Tables 3 and 4. Twelve patients required more than one dermatology visit before biopsy was performed. Table 5 summarizes immunohistochemical profiles. One case progressed to the tumor stage and subsequently died from complications.

Table 1: Demographic characteristics of patients diagnosed with MF initially treated as eczema

Parameter	Value	Range
Number of patients	16	—
Age (years)	58.2±6.4	50–65
Sex (M/F)	14/2	—
Duration before diagnosis (months)	12.6±7.4	6–24

Table 2: Clinical features and disease stage at diagnosis

Patient ID	Stage	Progression	Outcome
1–14	Patch/Plaque	No	Stable
15	Tumor stage	Yes	Deceased
16	Plaque	No	Family history of CLL

Table 3: Initial symptoms reported

Symptom	Patients (n)	Percentage
Chronic pruritus	15	93.7%
Erythematous patches	12	75%
Hyperkeratotic plaques	8	50%
Gradual spread	10	62.5%
Poor response to treatment	16	100%

Table 4: Previous treatments before MF diagnosis

Treatment	Patients (n)	Percentage
Topical corticosteroids	16	100%
Systemic corticosteroids	6	37.5%
Antihistamines	10	62.5%
Emollients	14	87.5%
Phototherapy	2	12.5%

Table 5: Immunohistochemical profile

Marker	Positive	Negative	Expression pattern	Interpretation
CD3	16	0	Diffuse epidermal	T-cell phenotype
CD4	15	1	Predominant	Helper T-cell
CD8	1	15	Focal	Cytotoxic subset
CD30	2	14	Focal	Activated cells
TCR	16	0	Clonal	Confirmatory for MF

DISCUSSION

Our results show that misdiagnosis of MF as chronic eczema remains a significant clinical challenge [5]. Prolonged use of topical corticosteroids may improve lesions temporarily, masking underlying malignancy and delaying biopsy.

In our cohort, the diagnostic delay averaged more than 12 months, consistent with international literature [2,7]. Repeated biopsies were necessary in some patients due to nonspecific early-stage histopathology [4].

The case with a family history of CLL highlights potential immunogenetic associations previously reported in the literature [3]. The fatal outcome in one patient underscores the importance of timely diagnosis.

These findings emphasize the need for greater clinical suspicion in cases of dermatitis unresponsive to appropriate therapy [8,9,10].

Early-stage MF frequently mimics chronic eczema, leading to delayed diagnosis and potential disease progression [11-13]. Dermatologists should maintain a high index of suspicion for MF in persistent or treatment-resistant dermatitis [14,15]. Early biopsy, appropriate immunohistochemistry, and clinicopathologic correlation are crucial for accurate and timely diagnosis in addition to therapeutic intervention [16].

Statement of Human and Animal Rights

All the procedures followed were in accordance with the ethical standards of the committee responsible for human experimentation (institutional and national) and with the 2008 revision of the Declaration of Helsinki of 1975.

Statement of Informed Consent

This retrospective study included pacients treated in our department between 2016 and 2024.All clinical data were analized

anonymously and no identifiable patient information was included. Therefore, individual informed consent was not required.

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